RISK CONTROL

ufg INSURANCE

Risk Control at United Fire Group | riskcontrol@unitedfiregroup.com | 800-828-2705

Injury management—physician's return to work report

Employee: _____ Physical exam time: _____ Left clinic: _____
Employer: _____ Family physician: _____
Date of last tetanus shot: _____ Employee I.D. number: _____
Date of visit: _____ Date of injury/illness: _____
Arrival time at clinic: _____ ☐ Initial visit: _____ ☐ Recheck: _____

Description of injury: _____
Is this injury related to work?: ☐ Yes ☐ No ☐ Undetermined
Physical finding (including x-ray): _____
Diagnosis: _____
Treatment/medication: _____

Disposition

☐ Return to regular duty: _____
☐ Return to work with restrictions (identify below) on _____ through _____.
☐ Next scheduled appointment on: _____ ☐ No future appointment necessary.
☐ Referred to: _____ Appointment date: _____

Physical Restrictions: Indicate restrictions, if applicable.

☐ Lifting/carrying maximum lbs.	100-75	74-50	49-35	34-20	19-11	10-0
Frequently (34%-66%)	☐	☐	☐	☐	☐	☐
Occasionally (0%-33%)	☐	☐	☐	☐	☐	☐

☐ Movement limitations	Bend	Twist	Squat
Frequently	☐	☐	☐
Occasionally	☐	☐	☐
Not at all	☐	☐	☐

☐ Restricted use of hand/arm ☐ Left ☐ Right ☐ Bilateral

	Grip	**Pinch**	**Push/pull**	**Reach above shoulder**
Frequently (34%-66%)	☐	☐	☐	☐
Occasionally (0%-33%)	☐	☐	☐	☐
Not at all	☐	☐	☐	☐

☐ Standing: Restrict to _____ hours per day. Sitting: Restrict to _____ hours per day.
☐ Keep body part affected clean and dry.
☐ Other: _____

Physician/examiner signature: _____ Date: _____

Please return within 24 hours

This form, supplied by United Fire Group, merely provides minimum guidelines for you to follow and may be utilized as a tool for fact-gathering purposes to assist in your investigation. The information requested above is not exhaustive and you should, at your own discretion, request any necessary additional information as the specific situation may warrant.